

**Arizona Department of Health Services (ADHS)
Division of Licensing Services (DLS)**

ZONING AUTHORITY CLEARANCE

HEALTH CARE INSTITUTION (Facility name of the health care institution)

Name_____

Street Address_____

City_____State_____Zip_____County_____

Health Care Institution Class or Subclass: _____

List each type of medical service to be provided:

CITY/COUNTY ZONING OFFICIAL:

To be completed by the City / County Zoning Official

1. Is the address/legal description from above properly zoned for the owners intended use? YES [] NO []

2. If not, what requirements will have to be met before the zoning clearance can be obtained?

a. _____

b. _____

3. Has a Special Use Permit been issued? YES [] NO []

Does it authorize the intended use? YES [] NO []

Name_____

Office_____

Signature_____

Please print

Telephone_____

Title_____

Date_____

City or County Zoning Official